

The Pediatric & Adolescent Center, Inc.

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Boise, ID 83713

William Bourquard, MD

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Acknowledgement of Receipt of Notice of Privacy Practices

The Pediatric & Adolescent Center reserves the right to modify the privacy practices outlined in the notice.

By signing this form, I acknowledge that I have received a copy of The Notice of Privacy Practices for The Pediatric & Adolescent Center.

Name of Patient (Please Print)

Date of Birth

Parent/Guardian (Please Print)

Parent/Guardian

(Required if patient is a minor or an adult who is unable to sign)

Date